

Case Number:	CM14-0151942		
Date Assigned:	09/22/2014	Date of Injury:	01/29/2008
Decision Date:	10/23/2014	UR Denial Date:	09/16/2014
Priority:	Standard	Application Received:	09/17/2014

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation, has a subspecialty in Interventional Spine Pain Management and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The patient is a 47-year-old male with a date of injury of 01/29/2008. The listed diagnoses per [REDACTED] are: 1. Cervical spine sprain/strain.2. Cervical disk displacement.3. Radicular symptoms of the upper limbs.4. Tardy ulnar nerve palsy.5. Carpal tunnel syndrome.6. Thoracic spine sprain/strain.7. Lumbar spine sprain/strain.8. Lumbar disk displacement.9. Radicular syndrome of lower limbs.10. Chondromalacia patella, knee.11. Sprain of knee/leg.12. Medial meniscal tear. According to progress report 06/25/2014, the patient presents with neck, mid back, low back and bilateral knee pain. Physical examination was deferred on this date. Progress report 05/14/2014, indicates the patient complains of aching neck, mid back, and low back pain that radiates to the lower extremities. Examination of the cervical spine revealed extension 40/60 degrees, flexion 35/50 degrees, left lateral bending 40/45, left rotation 70/80 degrees, right lateral bending 40/45, and right rotation 60/80 degrees. There was tenderness to palpation of the bilateral trapezii and C5 to C7 spinous processes. Examination of the thoracic spine revealed flexion 35/45 degrees, left rotation 15/30 degrees, and right rotation 15/30 degrees. There was tenderness to palpation of the bilateral trapezii, T5 to T6 spinous processes and T6 to T7. Examination of the lumbar spine revealed extension 15/25 degrees, flexion 35 to 60 degrees, left lateral bending 15 to 25 degrees, and right lateral bending 15 to 25 degrees. Examination of the left knee revealed tenderness to palpation of the lateral joint line and medial joint line. Extension was 0/0 degrees and flexion was 140 to 150 degrees. The utilization review denied the request on 09/16/2014.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

X-ray A/P and Lat to the Thoracic Spine: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Radiography

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178. Decision based on Non-MTUS Citation The Expert Reviewer based his/her decision on the MTUS ACOEM Practice Guidelines, Chapter 8, Neck and Upper Back Complaints, pages 177-178 and on the Non-MTUS Official Disability Guidelines (ODG); Guidelines for Radiography (X-ray, C-spine).

Decision rationale: This patient presents with neck, mid back, low back and bilateral knee pain. The provider is requesting x-ray of the thoracic spine. Review of the medical file does not indicate the patient has an x-ray of the thoracic spine. ACOEM guidelines on special studies for C-spine (p177,178) states radiography of the c-spine is not recommended except for indications including, "emergence of a red flag, physiologic evidence of tissue insult or neurologic dysfunction, failure to progress in a strengthening program, and clarification of the anatomy prior to an invasive procedure." Review of AME report indicates that the patient had an x-ray of the cervical spine and lumbar spine which revealed no evidence of soft tissue swelling or mass. The dates of the x-rays are not indicated. It does not appear that the patient ever had an X-ray of the T-spine and the request appears reasonable given the patient's persistent thoracic pain. Therefore this request is medically necessary.

Epidural Steroid Injection at C6-C7, Right: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46,47.

Decision rationale: This patient presents with neck, mid back, low back and bilateral knee pain. The provider is requesting an Epidural Steroid Injection to the right C6 to C7. MRI of the cervical spine from 06/04/2014 revealed at level C6 to C7, "focal central disk protrusion with annular tear affecting the thecal sac. Narrowing of the left neuroforamina that effaces the left C7 exiting nerve root. Disk measurements are between 2 to 2.5 mm." The MTUS Guidelines has the following regarding ESI under chronic pain section page 46 and 48, "Recommended as an option for treatment of radicular pain defined as pain in the dermatomal distribution with corroborated findings of radiculopathy." In this case, the patient presents with neck pain but no dermatomal distribution of pain is described. MRI also shows findings toward left-side, while the request is for right-side. Furthermore, the MTUS states, "there is insufficient evidence to make any recommendation for the use of epidural steroid injections to treat radicular cervical pain." Therefore, this request is not medically necessary.

Epidural Steroid Injection at L4-L5, Right: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ESI's Page(s): 46,47.

Decision rationale: This patient presents with neck, mid back, low back and bilateral knee pain. The provider is requesting an Epidural Steroid Injection at level L4 to L5 on the right. MRI of the lumbar spine from 06/04/2014 revealed at level L4 to L5, "diffuse disk protrusion with effacement of the thecal sac. Disk material and facet hypertrophy causing bilateral stenosis of neuroforamina that affects the left and encroaches the right L4 existing nerve root. Disk measurements are 3.3 mm." The MTUS Guidelines has the following regarding ESI under chronic pain section page 46 and 48, "Recommended as an option for treatment of radicular pain defined as pain in the dermatomal distribution with corroborated findings of radiculopathy." In this case, although the patient has radiating bilateral leg symptoms, they are not described in a dermatomal distribution to understand whether or not the symptoms correspond to L4 nerve distribution. Examination findings do not support radiculopathy either. MTUS requires a clear diagnosis of radiculopathy for a trial of an ESI. The provider also does not discuss whether or not an ESI was tried in the past with what results. Therefore, this request is not medically necessary.

Arthroscopic Exam of the Left Knee: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), under knee chapter, Arthroscopy

Decision rationale: Treatment reports from 08/09/2013- 08/04/2014 were reviewed. This patient presents with aching and constant left knee pain. MRI of the left knee from 06/04/2014 revealed myxoid degeneration in patellar horn, fabella, small knee joint effusion and bipartite patella. The provider is requesting an arthroscopic exam of the left knee, but does not provide a rationale for this request. ODG guidelines have the following regarding arthroscopy under its knee chapter, "An arthroscopy is a tool like a camera that allows the physician to see the inside of a joint..." For diagnostic arthroscopy, criteria include failure of conservative care, continued subjective complaints and inconclusive imaging clinical findings. ODG does not recommend arthroscopic surgery for knee arthritis, however. Review of AME report by [REDACTED] from 08/04/14 states "he does not present with any significant findings of the left knee." [REDACTED] further states that, "I do not see any indication of worsening left knee at this time." The provider has not provided a rationale for the arthroscopic examination. While the patient's current condition shows failure of conservative care, continued subjective pain, the imaging studies show degeneration that may explain the patient's symptoms. ODG guidelines do not

support arthroscopic surgery for knee degeneration and the provider does not provide any rationale for this request. Given the lack of discussion regarding the need for this invasive examination, therefore, this request is not medically necessary.

TENS Unit Rental x 5 months: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114.

Decision rationale: This patient presents with neck, mid back, low back and bilateral knee pain. The provider is requesting a TENS unit rental times 5 months. Per MTUS Guidelines page 116, TENS unit have not proven efficacy in treating chronic pain and is not recommended as a primary treatment modality but a one-month home-based trial may be considered for specific diagnosis of neuropathy, CRPS, spasticity, phantom limb pain, and multiple scoliosis. In this case, the provider is requesting a 50 month TENS unit rental but does not document a successful one month home trial. Therefore, this request is not medically necessary.

Urine Test x 1: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, UDT

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug testing Page(s): 43. Decision based on Non-MTUS Citation The Expert Reviewer based his/her decision on the MTUS Chronic Pain Medical Treatment Guidelines, Drug testing, page 43 and on the Non-MTUS Official Disability Guidelines (ODG) Urine Drug Screen, under its Pain chapter.

Decision rationale: This patient presents with neck, mid back, low back and bilateral knee pain. The provider is requesting 1 urine drug screen to monitor prescribed medications. Utilization review denied the request on 09/16/2014. The rationale section for the denial was cut off. Review of the medical file indicates the patient takes Tylenol No. 3, Motrin 800 mg, Prilosec 20 mg, and utilizes a compound topical cream. While MTUS Guidelines do not specifically address how frequent UDS should be obtained or various risks of opiate users, ODG Guidelines provide clear recommendation. ODG recommends once-yearly urine drug testing following initial screening with the first 6 months for management of chronic opiate use in low-risk patients. In this case, the patient is on T#3 which is an opiate. Review of the reports does not show that this patient has had excessive urine drug screen monitoring. Therefore, this request is medically necessary.